STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87907-001**

v

Blue Care Network of Michigan
Respondent
_____/

Issued and entered
this 21st day of April 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 19, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On February 26, 2008, after a review of the material submitted, the Commissioner accepted the request.

The issue in this matter can be resolved by analyzing the Blue Care Network (BCN) BCN 5 Certificate of Coverage (the certificate), the contract defining the Petitioner's health coverage. It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

The Petitioner has a history of osteoarthritis, degenerative joint disease, myofacial pain, and many other chronic conditions (e.g., ankylosing spondylitis, severe facet joint degeneration, degenerative disk disease, radiculopathy, and osteoarthritis of the knees and back). As a result

she requires pain management therapy. For relief of her symptoms she had regular osteopathic manipulation from XXXXX, MD, at the XXXXX. Dr. XXXXX is not in BCN's network of providers.

The Petitioner requested authorization and coverage for the therapy she received from Dr. XXXXX between June 28 and August 20, 2007, and approval for continuing services. BCN denied the request. The Petitioner appealed BCN's denial and, after exhausting BCN's internal grievance process, received its final adverse determination letter dated December 20, 2007.

III
ISSUE

Did BCN properly deny coverage for the Petitioner's osteopathic manipulation therapy from a non-network provider?

IV
ANALYSIS

Petitioner's Argument

On June 12, 2007, the Petitioner asked XXXXX, DO, her primary care physician (PCP), to submit a request to BCN for a consultation with Dr. XXXXX about her degenerative disc disorder and psoriatic arthritis. On June 14, 2007, BCN requested medical records from Dr. XXXXX to support the request and the records were submitted.

Although BCN had not given its approval for treatment, on June 28, 2007, the Petitioner was evaluated by Dr. XXXXX, who suggested addressing her multiple areas of dysfunction with the use of soft tissue osteopathic manipulation and possibly medical acupuncture. The Petitioner began receiving therapy (Greenman Muscle-energy Technique, Strain-Counterstrain or Jones Counterstrain Technique, and Myofacial Release) that lasted until August 20, 2007.

On July 9, 2007, BCN denied the request for a referral to Dr. XXXXX on the basis that "acupuncture is investigational for all indications." Dr. XXXXX sent a letter to BCN clarifying that the referral was for osteopathic manipulation and not acupuncture, and BCN, in letters dated September 6 and December 20, 2007, BCN again denied coverage, saying the care is available

within its network.

The Petitioner says she tried numerous physicians and various treatments but did not get any relief until her treatment with Dr. XXXXX. She says her PCP supports continuing treatment from Dr. XXXXX as medically necessary. She also says that while BCN said there were network providers available to provide the therapy, it failed to tell her which ones offer the exact methods Dr. XXXXX uses.

The Petitioner argues that BCN should cover the cost of the therapy provided by Dr. XXXXX because his techniques are not available from any network providers and they offer significant relief from her pain.

Respondent's Argument

In its final adverse determination, BCN denied coverage because Dr. XXXXX is not part of its network and prior authorization was not obtained. BCN bases its position on the certificate, which states in pertinent part:

> **PART 2: EXCLUSIONS AND LIMITATIONS**
>
> This section lists the exclusions and limitations of your BCN 5 Certificate.
>
> ***2.01 Unauthorized and Out-of-Plan Services***
>
> Except for emergency care as specified in Section 1.05 of this booklet, health, medical and hospital services listed in this Certificate are covered **only** if they are:
>
> - Provided by a BCN-affiliated provider and
> - Preauthorized by BCN.
>
> Any other services will not be paid for by BCN either to the provider or to the member.

BCN denied coverage because the Petitioner did not obtain authorization before beginning treatment as required by the certificate. BCN further says that care was available within its network of providers (from an MD, DO, physical therapist, or chiropractor) and it was not necessary for the Petitioner to seek treatment outside the network.

Commissioner's Review

The Commissioner carefully reviewed the arguments and documents the parties submitted. The issue in this case is whether BCN properly denied coverage for the Petitioner's services from Dr. XXXXX.

The Petitioner's certificate covers the type of services she received. However, those services must be approved in advance by BCN before they are received from an out-of-network provider. That requirement is consistent with managed care contracts. BCN, a health maintenance organization (HMO), operates within a network of providers who sign contracts and agree to accept BCN's negotiated rates. The negotiated rates are a primary method of containing costs that ultimately benefits every member. A fundamental premise of HMOs is the centralization of health care delivery within its network of providers. If an HMO member uses an out-of-network provider, payment for the out-of-network services may be greatly reduced or even excluded entirely by the HMO.

On June 28, 2007, the Petitioner was evaluated by Dr. XXXXX and shortly thereafter began treatment without obtaining authorization as required by the certificate. In its July 9, 2007, letter to the Petitioner, BCN declined to approve the services from Dr. XXXXX, an out-of-network provider, but the Petitioner continued the treatment.[1] The July 9, 2007, letter informed the Petitioner of her right to file a grievance over BCN's denial.

While the Petitioner is free to select a health care provider that she feels is best qualified, the certificate determines how benefits are paid. The certificate covers osteopathic manipulation from an out-of-network provider only when pre-approved by BCN.

The Petitioner says that her PCP is in support of continued treatment with Dr. XXXXX and that she has failed all other network treatment. However, her PCP cannot authorize out-of-

[1] There was some confusion about the exact nature of Dr. XXXXX services. The July 9, 2007, letter denied acupuncture services. Nevertheless, BCN gave no approval for any kind of services from Dr. XXXXX.

network services without approval from BCN.

The Petitioner does not believe that the services she received were available within BCN's network and says BCN did not identify providers for her. However, it does not appear from this record that BCN had a reasonable opportunity to work with the Petitioner and her primary care physician to identify appropriate providers; the Petitioner began treatment after her first visit with Dr. XXXXX without waiting for approval from BCN (or filing a grievance after she received BCN's denial). The Commissioner, therefore, cannot make a finding on whether the needed services were available within BCN's network, and upholds BCN's denial solely on the basis of the Petitioner's failure to obtain prior approval.

If the Petitioner needs further osteopathic manipulation, she should contact BCN and be directed to a network provider who can provide that therapy.

The Commissioner finds the Petitioner did not meet the requirement in Section 2.01 for pre-authorization and finds BCN's final adverse determination is consistent with its Certificate.

V
ORDER

Respondent BCN's December 20, 2007, final adverse determination is upheld. BCN's denial of coverage for services obtained from an out-of-network provider is in accordance with the Petitioner's certificate.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.